2004/2005 Alaska Vaccine Distribution Program

Provider Certification Form

Page 1 – General Registration

PLEASE PRINT OR TYPE

Facility Name _____

Immunization Contact for Facility _____

Shipping Address: _____

_____

_____

Mailing Address: (if different) _____

_____

_____

Phone No. _____ **Fax No.** _____

Email Address: _____

***Approximate* patient census in your facility, per age group:**

- Required for determination of anticipated monthly vaccine use
- Information will remain confidential within the Alaska Immunization Program

Under 1 yr _____ **1 – 6 yrs** _____ **7 – 18 yrs** _____ **19+ yrs** _____

Do you provide yellow fever vaccine? Yes No

If yes, please list your **Yellow Fever Authorization #:**

For providers <u>outside</u> the Anchorage area:

Is there any pertinent shipping information about which we should be aware?
(i.e., unusual clinic hours, delivery constraints, etc.)

_____

_____

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Page 2 – Certification

As a condition for receiving vaccines from the Alaska Department of Health & Social Services, I/we have read the Federal/State Requirements for the use of state-supplied vaccine and agree to the following terms:

1. I certify that, in administering vaccine received from the Alaska Immunization Program for use in my practice, **I will provide patients/parents/guardians a copy of the currently approved "Vaccine Information Statement" (VIS) before administering each dose of vaccine.** I will record the following information in the patient's medical record:

   Date vaccine administered;
   Manufacturer name and **lot number** of the vaccine;
   Signature and professional title of person administering the vaccine;
   Address of facility in which the vaccine is administered;
   Printing Date of VIS.

2. I will **charge no patient, parent, legal guardian, or third party a fee for the cost of the vaccine** received from the Alaska Immunization Program. I recognize that I may charge a nominal administration fee. However, **clients will not be denied state-supplied vaccine due to inability to pay an administrative fee.** I will post a public sign in my office stating this policy.

3. I will submit **monthly reports** to the Alaska Immunization Program office, including:
   - Vaccine Order Form
   - Vaccine Usage Report
   - Vaccine Return Form
   - Copies of Temperature Logs from main refrigerator/freezer used for vaccine storage

   I understand that, if the designated reports do not accompany my vaccine order, the order will not be filled.

4. I will **return all spoiled or expired vaccine** (including partial vials) to the Alaska Immunization Program along with the completed *Vaccine Return Form.*

5. I will ensure that all **vaccines are maintained at the appropriate temperatures** as published in the vaccine product insert. I will ensure that vaccine storage temperatures are monitored and recorded twice daily and that refrigerator/freezer temperature logs are maintained for a minimum of **three years**.

6. I will, in accordance with Federal requirements, allow the Alaska Immunization Program access to my office for the purpose of monitoring vaccine storage and handling practices.

7. ***(For varicella vaccine only)*** I will ensure that:

   a. my facility has a **freezer** (with a separate, sealed freezer door) that reliably will maintain an average temperature of +5° F (–15° C) or colder;

   b. facility staff are instructed in the **special handling requirements** of varicella vaccine and the vaccine will be stored and handled according to the product insert.

→ **I understand and accept the terms outlined above. I agree to ensure that all medical personnel who administer state-supplied vaccine under my supervision understand and agree to these requirements.**

Physician/ Advanced Nurse Practitioner Representing Facility ***(Signature)***	Physician/ Advanced Nurse Practitioner Representing Facility ***(Please Print)***	Date

Alaska Medical License No.	Medicaid Provider No.

Important: List names and numbers for associate MDs/ANPs in the facility on the following page.

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Page 3 – Associate Providers in Facility

Facility Name:

Please list associate physicians/ advanced nurse practitioners in the facility:

Print or Type:

Name	AK Medical License #	Medicaid Provider #

(please copy this page if additional space is needed)